IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
KARL B. KURTZ – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3314 9139

August 15, 2006

Clark N. Graebel, Administrator
Idaho State Veterans Home - Lewiston
821 Twenty First Avenue
Lewiston, ID 83501

Provider #: 13A033

Dear Mr. Graebel:

On **July 26, 2006**, a fire safety survey was conducted at Idaho State Veterans Home - Lewiston by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be widespread deficiencies that constitute no actual harm, but have potential for more than minimal harm and are not an immediate jeopardy, as evidenced by the attached CMS Form 2567L whereby corrections are required.

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Date Certain" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 28, 2006**. Failure to submit an acceptable PoC by **August 28, 2006**, may result in the imposition of civil monetary penalties by **September 18, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **August 30, 2006 (Date Certain)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **August 30, 2006**. A change in the seriousness of the deficiencies on **August 30, 2006**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 30, 2006** includes the following:

Denial of payment for new admissions effective **October 26, 2006**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 26, 2006**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact me with your written credible allegation of compliance at the following address:

Bureau of Facility Standards — DHW

3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036

If you choose and so indicate, the POC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **July 26, 2006** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR 488.331, you have the opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send a written request which states the specific deficiencies being disputed, and explains why you are disputing those deficiencies. This request must be received by **August 28, 2006**.

All required information should be as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

If your request for informal dispute resolution is received after **August 28, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

MARK P. GRIMES
Supervisor
Facility Fire Safety and Construction

MPG/dmj

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13A033	A. BUILDING 01 - ENTIRE BUILDING B. WING _____	07/26/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ISVH - LEWISTON	821 21ST AVE LEWISTON, ID 83501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story, protected non-combustible Type II(111) construction. It is fully sprinklered with a partial basement. The basement houses hot water heaters and air handling equipment. The facility was built/completed on June 10, 1994. Currently it is licensed for 66 SNF/ NF beds. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey completed on 26 July, 2006. The facility was surveyed under the LIFE SAFETY CODE, 200 Edition, Existing Health Care Occupancy, adopted 11 March, 2003. In accordance with CFR 42, 483.70. The Survey was conducted by: Chris Laumann, Health Facility Surveyor	K 000		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by:	K 025		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Clark D Graebel	Admin.	8-28-06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 025	Continued From page 1 Based on observation and staff interview, the facility failed to assure that all smoke barriers would provide protection against passage of smoke between smoke compartments. This deficient practice affected staff and all 56 residents in four of four smoke compartments. At the time of survey the census was 56 and the licensed capacity was 66. Findings include: During the facility tour on 26 July, 2006 between the hours of 9 AM and Noon, it was observed that the attic smoke barriers located above the cross-corridor smoke doors in all corridors, i.e. the North wing barrier, the East wing barrier, and the West wing barrier had penetrations (unsealed openings) that would allow the passage of smoke into all four smoke compartments in the event of a fire. Each penetration was due to duct work penetrating the smoke rated wall, leaving numerous gaps, finger width in size surrounding piping and duct work. These penetrations were observed and acknowledged at the time by the Maintenance Supervisor. Actual NFPA Standard: NFPA 101, Sect. 8.3.2 requires that smoke barriers be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof.	K 025		

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K 039 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility had not ensured a corridor was kept free of equipment not in immediate use. This deficient practice affected all staff and all 56 residents in three of four smoke compartments. At the time of survey the census was 56 and the licensed capacity was 66. The findings included: On 26 July, 2006 between the hous of 9:00 AM and 12:00 Noon it was observed that linen baskets, various medical equipment, lifting machines, wheelchairs, and numerous other pieces of equipment were permanently being stored within the North wing corridor, the East wing cooridoor, and the West wing cooridoor. Staff stated at the same dates/times of the observations that the equipment was permanently stored in the cooridoor. The equipment placement in the corridor placed a restriction on exit access and did not allow full use of the corridor during an emergency/fire. The permanent storage of equipment is strictly forbidden within a means of egress by federal regulation NFPA 101. Observations were witnessed and noted by survey team and facility maintenance supervisor.	K 039		

Bureau of Facility Standards

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C 000	INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The facility is a single story, protected non-combustible Type II(111) construction. It is fully sprinklered with a partial basement. The basement houses hot water heaters and air handling equipment. The facility was built/completed on June 10, 1994. Currently it is licensed for 66 SNF/ NF beds. The following deficiencies were cited during the annual Fire Life Safety survey completed on 26 July, 2006. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The Survey was conducted by: Chris Laumann, Health Facility Surveyor	C 000		
C 230	02.106,02,b b. Existing facilities licensed prior to the effective date of these rules, regulations and minimum standards and in compliance with a previous edition of the Life Safety Code may continue to comply with the edition in force at that time. This Rule is not met as evidenced by: Refer to Federal K tags 025, and 039	C 230		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Clark J. Graebel

TITLE: Admin.

(X6) DATE: 8-28-06

Plan of Correction for survey/ conducted 7-26-06

K 025NFPA 101 Life Safety Code Standard
Corrective action accomplished for those residents found to have been affected by the deficient practice was: Areas identified during the survey were sealed with fire proof caulking.

How we will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Any future penetrations made to smoke barriers by contractors and/or maintenance will be sealed .

What measures will be put into place or what systematic changes you will make to insure that the deficient practice does not recur: Any future penetrations made to smoke barriers by contractors and/or maintenance will be sealed. This will also be put on the preventive maintenance system.

How the corrective action will be monitored to ensure the deficient practice will not recur: Will be monitored per the preventative maintenance system.

Corrective action to be completed by August 15, 2006.

K 039 NFPA 101 Life Safety Code Standards:
Corrective action accomplished for those residents found to have been affected by the deficient practice was: Impromptu meetings were held with nursing staff on how we could accomplish this deficient practice. Nursing staff gave suggestions as to how to accomplish this. They were informed that the hallways needed to be clear of items such as the linen carts, Hoyer lifts, dirty hampers, and wheelchairs. They were informed that when these items were not in use for 30 minutes or more they were to be put away.

How we will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: DNS, Maintenance Foreman, Administrator, RNC nurse will do periodic checks to ensure the deficient practice does not re-cur.

What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: DNS, Maintenance Foreman, Administrator, RNC nurse will do periodic checks to ensure the deficient practice does not re-cur. In service has been conducted informing nursing staff of plan of correction. These in services were conducted on 8-22-06 and 8-24-06. We have added to the Facility Environment QA tool a section to monitor for Hallways being clear of equipment.

How the corrective action will be monitored to ensure the deficient practice will not recur: We have added to the Facility Environment QA tool a section to monitor for hallways being clear of equipment.

Corrective action will be completed August 24, 2006.

C 230-Refer to plan of correction for K 025 and K 039.